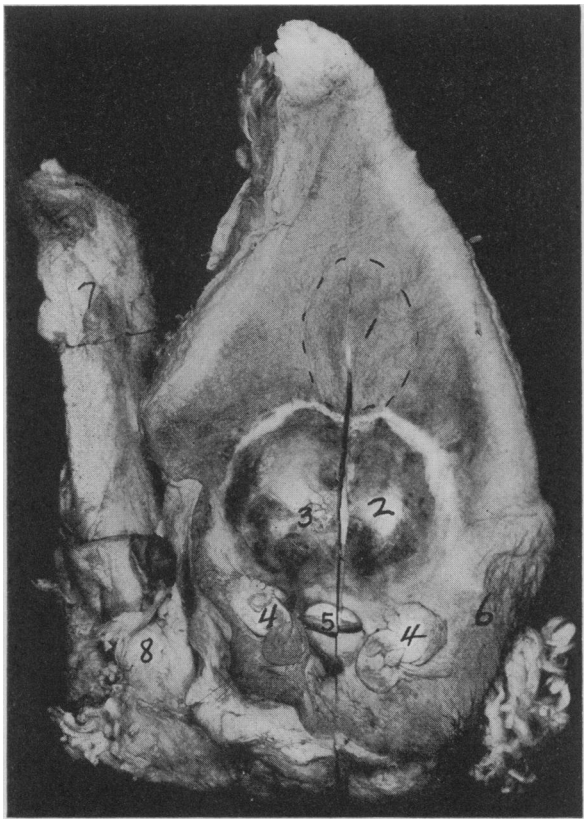

Fig. 4.—The numbers indicate the following: 1. Ventral hernia outlined. 2. Mass over the pubic region. 3. Opening through which urine seeped. 4. Labia minora. 5. Vagina. 6. Labia majora. 7. Distended ureter. 8. Sac-like dilatation of ureter.

of right kidney; also the right ureter. These all show a generalized dilatation, dilatation being most marked throughout the upper portion of the ureter. In the right kidney are two small densities which are apparently calculi. No visualization noted throughout the left kidney and ureter. There are several areas in the region of the lower pole which are suggestive of calculi.

Fig. 2 shows film, taken fifteen minutes after injection, and shows accentuation throughout the right, the ureter being a centimeter in diameter. The bladder consists of a small pouch which lies on the right side of the pelvis. No visualization of the left.

Fig. 3 shows film, taken thirty minutes after injection, and shows a slight decrease in visualization throughout the right with no visualization on the left. Sac-like bladder is somewhat accentuated.

The pelvis reveals a congenital anomaly in which there is an entire absence of symphysis.

She became progressively weaker, suffering intensely from nausea and taking very little nourishment. On August 23 she was paralyzed on the left side (arm and leg) and died at 7:10 a. m.

Autopsy.—Autopsy was done by Dr. A. M. Moody, the findings of which were as follows: A marked edema of the brain was noted. Healed tuberculosis at apices of both lungs and several scars. Pleural adhesions on both sides to the chest wall. Right kidney very large and congested. No stones were present, but a quantity of pus and gravel. Pronounced hydronephrosis and pyonephrosis; widely dilated ureter, which ended as a rounded, elongated sac. There was no bladder, the sac-like dilatation of the ureter taking its place, and lying entirely on the right side of the pelvis. On the left side was a very small kidney, about the size of an English walnut, imbedded in a large amount of fat and fibrous tissue which held it firmly in place and made it very difficult to remove. (This was the mass felt on the left side.) There was no ureter on the left side. The left kidney probably never functioned. There was a chronic, retrocecal appendix with many dense adhesions. Uterus, tubes, and ovaries were normal. There was a small ventral hernia just above the mass over the pubic region, in the sac of which the omentum was firmly adherent. In the wall of the hernia, under the skin; there was some scar tissue, although none showed on the surface. This must have been the place where the umbilical cord was attached. There was a total absence of the pubic symphysis, and of the ascending and descending rami of the pubis on both sides.

The cause of death was exstrophy of the bladder, causing ascending ureteritis and pyelonephritis of right kidney.

It is remarkable that she had attained the age of sixty years with such an ascending infection, and also that she could walk with no apparent change in gait, although the pelvic girdle was so incomplete.

422 Medical Building.

SACCULAR DILATATION OF SAPHENOUS VEIN

SIMULATING TUMOR OF THE GROIN

By Don D. Weaver, M. D.
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THE following report may be of interest for several reasons—first, because of its rare occurrence. Not more than ten or eleven instances are found in the literature since 1835, when Boinet [1] reported his first case in the medical journal of Paris. It is of interest, also, because of the fact that with every patient so reported the surgeon has been caught off guard and led to make an incorrect preoperative diagnosis.[2 to 8]

The present case is distinctive because of the large size of the mass, and in that it contained a solid clot, presenting a hard lump in the groin instead of the usual soft swelling, which, in most cases, has been mistaken for femoral hernia.

REPORT OF CASE

S. M. Age, 54. Entered hospital December 29, because of a hard swelling in left groin. Family history negative. Personal history negative, except for injury ten years ago.

Patient stated condition began in 1930, when she noticed a soft, compressible lump in the left groin.

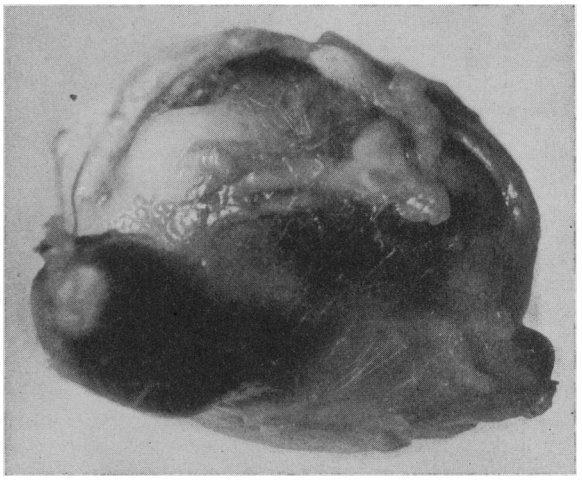

Fig. 1.—Sac unopened.

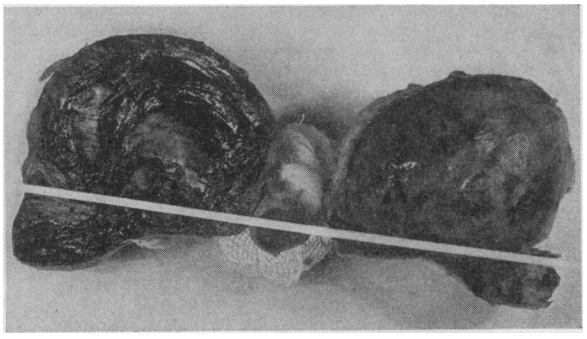

Fig. 2.—Sac split open, probe in vein, clot removed from one side.

This persisted for three years, but was not painful. About a week before she consulted us she noticed that the tumor-like growth was becoming larger, harder, and was more fixed, and that a dull pain was present.

Examination.—Entirely negative except for a large, firm, smooth swelling in the left groin, just distal to Poupart's ligament. The mass projected about 1½ to 2 centimeters above the level of the adjoining surface of the thigh. The tumor was circumscribed and movable in underlying structure. The dome was tense and smooth; no pain or palpatation; no fluctuation. Adjoining lymph glands were palpable, but not tender.

Patient seen in Cancer Clinic on December 30. Diagnosis: Tumor of groin. Excision and biopsy were advised.

On January 4 the patient was operated upon, and the swelling was found to consist of a large aneurysmal saccular pouch, extending from the saphenous vein close to its junction with the femoral. The sac was completely filled by a large solid clot, while the clot in the vessel lumen gave evidence of being more recent. The vein was doubly ligated, both proximal and distal to the sac, and was removed. Convalescence was uneventful.

Pathologic Report (By Dr. Gertrude Moore).—The submitted specimen is said to consist of an aneurysmal sac from the saphenous vein of the left leg. The distal vein measures 2 centimeters in diameter, the proximal vein 9 millimeters. Between these two extremities there is a sacular dilatation measuring 6 x 5 x 4 centimeters, moderately firm in consistency, somewhat fluctuant. There is a little perivascular fat, and adhesions on the surface. Cut sections through this sac show a large mass of fresh and old coagulated blood, some of the blood near the epithelial lining undergoing organization. The wall has a fairly uniform measurement of one-half to three-quarters of a millimeter in thickness. The endothelial lining appears fairly smooth and consistent throughout. The sac could be evacuated of its contents and leaves a fairly smooth glistening endothelial lining. It is moderately transparent, and the perivascular small vessels can be seen on the surface from the internal aspects. There is no evidence of rupture seen.

Diagnosis.—Aneurysmal dilatation of the left saphenous vein, sacular in type, showing beginning organization of the contents.

COMMENT

Etiology.—Under normal conditions veins are subject to many variations both in size and location.

In the veins of both extremities are found valves, which also vary in number and location and development. They are most numerous in the superficial veins of the lower extremity, where they prevent back flow and also serve to support the column of blood. Incompetency of these valves has long been associated with varicose veins of the leg.

Inasmuch as there are no valves in the vena cava and external iliacs, considerable pressure could be thrown upon the first portion of the saphenous if the valve guarding the opening between the saphenous and femoral were incompetent.

Often the history of injury and the mode of onset are helpful in making a diagnosis.

Diagnosis.—These conditions usually present a small swelling in the groin closely resembling a femoral hernia for which they are often mistaken. The swelling frequently disappears on lying down, and may give a slight impulse on coughing. The swelling is usually softer than that of a hernia, and is more easily compressed; but returns at once when in the erect position or upon relief of pressure. A thrill may be felt at times. The history of the injury and the mode of outset may be valuable in the diagnosis.

Without a doubt, the diagnosis of this condition should present no difficulties were it not for its rare occurrence.

400 Twenty-ninth Street.

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A NEW VAGINAL RETRACTOR*

By HENRY L. WHITE, M. D.
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IN placing a new retractor before the profession one is reminded that this field is already crowded. A few minutes with an instrument catalogue will convince anyone of this. However, and notwithstanding the above, I am going to describe a new retractor.

This retractor has been in use in my work for about five years. It is on every set-up for "lower work," and in most cases has met all the requirements asked of it. There is no claim made for the regular, well-known weighted type of Auvard's vaginal speculum. The attached lateral wings are original with me, as far as I know, and these, with Auvard's speculum, make up the described retractor.

In operation it is placed in the vaginal vault, using a small amount of any sterile lubricant; this after draping and placing a rectal towel, which

* Read before the Obstetrics and Gynecology Section of the California Medical Association at the sixty-second annual session, Del Monte, April 24-27, 1933.